Food and Drug Administration
Center for Food Safety and Applied Nutrition
Office of Special Nutritionals

ARMS#

12979

3 - OUTPATIENT

000001

ARMS # 12979

OFFICE NOTE
PATIENT: [redacted]
DOB: [redacted]
DOV: 5/14/98

HISTORY: Comes in for blood pressure check. Has been taking a medication called Metabolife containing Ma Huang and Guarana 40 mg caffeine for weight loss. She has been noticing that her heart has been pounding so she stopped taking it on Monday and has been feeling better. However, co-worker's checked her blood pressure and it was markedly elevated. She has had no chest pain. Some slight sensation of shortness of breath but no dyspnea on exertion, no headaches.

PHYSICAL EXAMINATION: Weight is 173 pounds, blood pressure is 168/108, pulse 96 to 100 and regular. LUNGS: Clear to auscultation. No rales. CARDIAC: Regular rate and rhythm. Tachycardic S1, S2 without murmurs, clicks, rubs, or gallops. Hyperdynamic pericardium. EXTREMITIES: No cyanosis or edema. Radial pulses 2+ bilaterally.

ASSESSMENT/PLAN:

1. Adverse drug reaction secondary to Metabolife. FDA report will be filled out. Adalat CC 30 mg p.o. q. day. Return in two weeks. Call if she should develop chest pain.

[redacted] M.D.

Patient Name: [redacted] DOB: [redacted] ARMS# 12979

Date MAY 15 1998 CC: 3 month BP check

MAY 08 1998 MAY 08 1998

wt 178 BP 140/90 P 96

meds: OTC Allergy med.
Stopped taking metabolife on monday
~~Allergy~~ - NKA
Adalat CC 30mg QD. re / 2 weeks off med.

[redacted]

July 16/1998 med: propoxy-N/Apap 100/650, Lipitor 20mg, ASA Iron, Prinzoral allergies, ferrous sulfate tab.

allergies: NKA

OFFICE NOTE
PATIENT: [redacted]
DOV: 6/3/98
DOB:

HISTORY: Presents with feeling shaky and left-sided chest pain for the past two days. She has difficulty sleeping and complains of a rapid heart beat. No loss of consciousness. She also feels that she is sort of racing around the office. Of note, she recently had a problem with Metabolife and was placed on Adalat which she ran out of one week ago.

MEDICATIONS: Drixoral tablets one to two tablets per day.

FAMILY HISTORY: Negative for coronary artery disease.

SOCIAL HISTORY: Negative for cigarettes, alcohol, or caffeine intake.

PHYSICAL EXAMINATION: Weight 171 pounds which is stable. Blood pressure 160/104, rechecked at 158/108, pulse is 88 to 108 and regular. NECK: Thyroid normal. Carotids brisk upstroke. No adenopathy. LUNGS: Clear to auscultation. CARDIAC: Regular rate and rhythm. S1, S2 without murmurs, clicks, rubs, or gallops. EXTREMITIES: No cyanosis, clubbing, or edema. EKG is sinus tachycardia. No ischemic ST or T wave changes.

ASSESSMENT/PLAN:

1. Tachycardia. Rule out hypothyroidism, possibly secondary to Metabolife diet pills. Place on Atenolol 50 mg p.o. b.i.d. Recheck in two days.

[redacted]

CFSAN PROJECT # 12979
SAN TRAK3 # 98-1432
JTB
Exhibit 5, 1 of 2

98 OCT -6 P2:36

CLINICAL REVIEW/OSN IFS-452
RECEIVED

OFFICE VISIT
PATIENT: [redacted]
DOV: 6/5/98
DOB: [redacted]

HISTORY: Follow-up blood pressure. Has been feeling a little bit fatigued on the Atenolol and having some difficulty thinking straight while working at the chocolate factory standing up for a long time at a counter. She bent over and then stood up and felt "racing". Further description of this was a lightheaded sensation like she was going to almost pass-out. She did not lose consciousness or lose her vision. She stood still and, in fact, looked up which seemed to resolve the symptoms. She does not remember her heart racing. Has not had any more symptoms like this.

PHYSICAL EXAMINATION: Weight 176 pounds which is up five pounds. Blood pressure 170/100 seated position right and left arm, supine 172/90, standing 174/112. Pulse is 80 and ranged up to 100 and regular. CARDIAC: Regular rate and rhythm. S1, S2 without murmurs, clicks, rubs, or gallops. EXTREMITIES: No edema.

ASSESSMENT/PLAN:

1. Hypertension, tachycardia. Likely secondary to diet medicine. Increase Atenolol to 100 mg b.i.d. Should she have a repeat episode of the dizziness, will place Holter monitor. Recheck in two weeks.

[redacted] M.D.

CFSAN PROJECT # 12979
SAN TRAK 3 # 98-1432
JTB
Exhibit 5, 2 of 2

OFFICE NOTE
PATIENT: [redacted]
DOV: 6/18/98
DOB: [redacted]

HISTORY: Follow-up blood pressure. Has been feeling fine as far as blood pressure. Unfortunately, she has developed left arm pain from her worker's comp injury. She has seen Dr. [redacted] in the past and has started taking ibuprofen 800 mg b.i.d. to t.i.d. again. This is not relieving the pain much. She has not had any chest pain, palpitations, shortness of breath, or leg swelling. The patient also mentions she is developing a rash on her face. She has had this for approximately one year but seems to be getting worse over the last couple of days. She does not necessarily notice that it gets worse with spicy or hot foods or emotions.

PHYSICAL EXAMINATION: Blood pressure 150/100, after some rest 152/94, pulse is 80. SKIN: There is erythema of the cheeks and forehead with a few pustules. The nose is slightly reddened. No rhinophyma.

ASSESSMENT/PLAN:

1. Hypertension. Add hydrochlorothiazide 50 mg q. day along with the Atenolol 100 mg b.i.d. Recheck in one month.
2. Rosacea vs. lupus. Patient most recently had blood test with normal LFT's and renal function. Recommended getting blood tests specifically to rule out lupus but the patient did not wish to do so. Trial of Metro-gel b.i.d.
3. Lateral epicondylitis. The patient has point tenderness over the lateral epicondyle. Ibuprofen does not seem to be having much effect on her blood pressure. Recommended following up with her worker's comp doctor for treatment of lateral epicondylitis.

[redacted] M.D.

OFFICE NOTE
PATIENT: [redacted]
DOV: 6/22/98
DOB: [redacted]

HISTORY: Presents with heaviness in her chest ever since last night. Episodes of sweating and tingling in her left arm. She also feels abdominal cramping, dizziness, shortness of breath, and tiredness. The patient stopped her Atenolol after has last visit and has only been taking hydrochlorothiazide 50 mg per day.

PHYSICAL EXAMINATION: Weight 168 pounds which is down six pounds. Blood pressure 180/100. Pulse is 80. GENERAL: The patient appears anxious, is tearful. SKIN: Moist. LUNGS: Clear to auscultation. CARDIAC: Regular rate and rhythm. S1, S2 without murmurs, clicks, rubs, or gallops. ABDOMEN: Soft with mild left lower and right lower quadrant tenderness. No rebound or guarding. EXTREMITIES: No edema. Capillary refill less than two seconds.

EKG performed in the office with poor R wave progression. Nonspecific high lateral ST and T wave changes.

ASSESSMENT/PLAN: [redacted]

1. Concerning constellation of symptoms with slightly changed EKG. Will admit patient to the hospital to rule out MI and consider treadmill at discharge.

[redacted] M.D.

000007

[redacted]

06/22/1998 [redacted]
61 years Female White

[redacted]

[redacted]
Dept:
Room:
Oper: [redacted]

Rate 111 . Sinus tachycardia, rate 111.....Normal P axis, rate >= 100 D.O.S:
PR 159 . Nonspecific Lateral T abnormalities.....T neg, T/QRS ratio <.07 I,L,V5-V6
QRSD 72
QT 319
QTc 433

--AXIS--
P 47
QRS 52
T 16

1) Sinus Tach 111 BPM.
2) Poor R wave progression - COPD / BMI / Lead Placement.
3) Nonspecific Lat ST/T wave D cannot exclude ischemia
4) Compared to EKG of 5/98 #1 & #3 are new

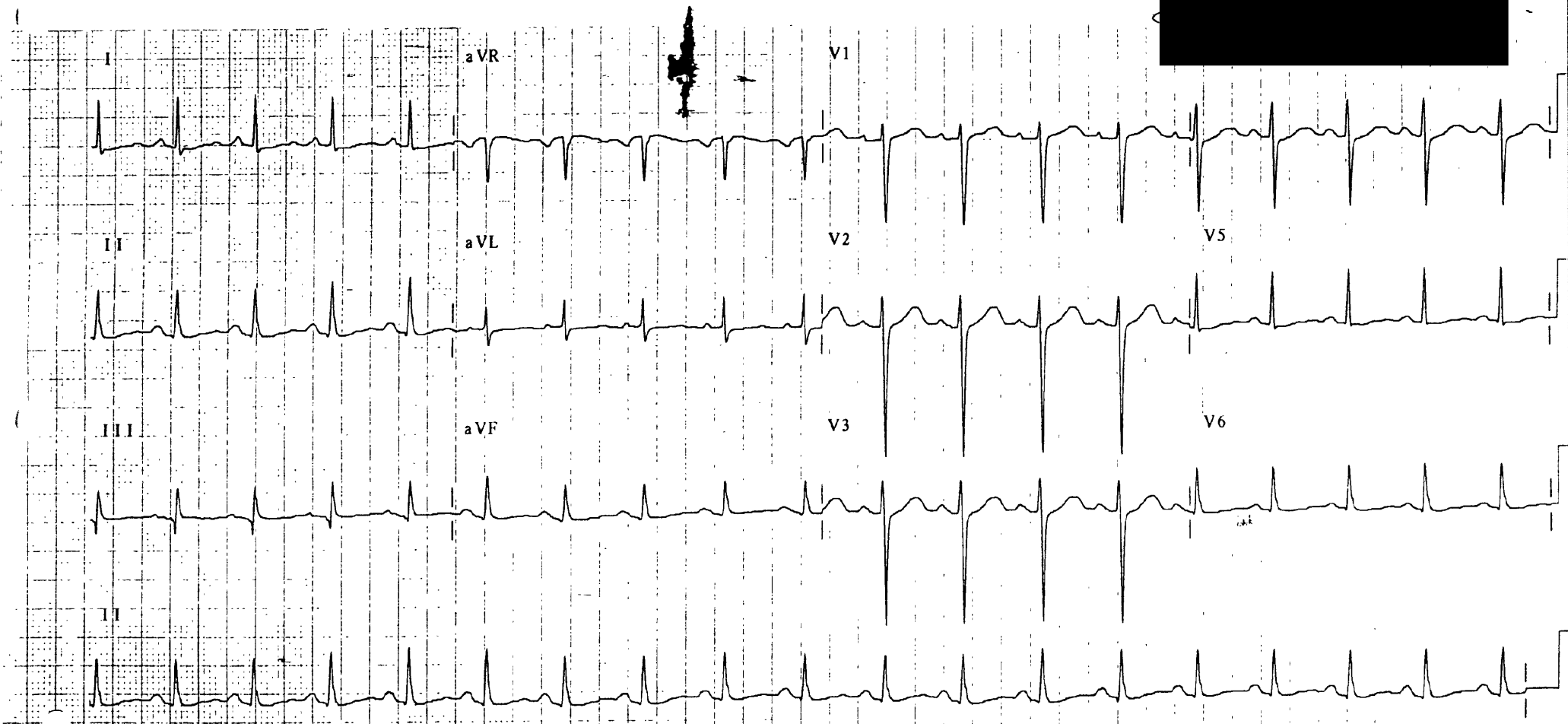
Requested by: [redacted]

800000

- BORDERLINE ECG -

PRELIMINARY-MD MUST REVIEW

[redacted]



LOC [redacted] Speed:25 mm/sec Limb:10 mm/mV Chest:10 mm/mV

F 60~ 0.5-150 Hz W [redacted]

OFFICE NOTE
PATIENT: [redacted]
DOB:
DOV: 7/16/98

HISTORY: Follow-up MI and bypass. Doing very well with some shortness of breath. She has not started cardiac rehab exercises. Is seeing Dr. [redacted] for this. Has used Sinutab for allergies with good relief. She had some problems with anemia but the iron was making her feel sick to her stomach so she only taking one per day.

PHYSICAL EXAMINATION: Blood pressure is 112/82, pulse is 90. LUNGS: Clear to auscultation with decreased breath sounds in the left base. Dullness to percussion in this area approximately ¼ of the way up. CARDIAC: Regular rate and rhythm. S1, S2 without murmurs, clicks, rubs, or gallops. Well healing midline scar. EXTREMITIES: No edema.

ASSESSMENT/PLAN:

1. Status post coronary artery disease. Doing well. Follow-up with Dr. [redacted] for cardiac rehab.
2. Pleural effusion. Repeat chest x-ray now.
3. Hypertension now resolved.

[redacted]

OFFICE NOTE
PATIENT: [redacted]
DOB:
DOV: 9/25/98

HISTORY: Three weeks of nasal congestion, drainage, and cough productive of green phlegm. Copious nasal discharge. No headaches, fevers, chills. No dental pain. No sore throat. She had some heaviness and tightness in her chest. She has been having this for the past week. She does not feel exactly like her heart pain did. This morning, she ran on the treadmill with Dr. [redacted] Dr. [redacted] was called and it was reported that there were no ischemic changes.

MEDICATIONS: Cholesterol medicine at bedtime. Aspirin in the morning.

PHYSICAL EXAMINATION: Weight 159 pounds, blood pressure 138/90, temperature 99.0, pulse 120. HEENT: Tympanic membranes clear with good light reflex. Nares edematous with copious amounts of yellow discharge. Oropharynx mild hyperemia. Tonsils normal. NECK: No adenopathy. LUNGS: Clear to auscultation. No wheeze, rales, or rub. CARDIAC: Regular rate and rhythm. S1, S2 without murmurs, clicks, rubs, or gallops. EXTREMITIES: No cyanosis, clubbing, or edema.

ASSESSMENT/PLAN:

1. Sinusitis. Bactrim DS one p.o. b.i.d. x10 days. Atrovent nasal spray 6% two sprays q.i.d. p.r.n.
2. Coronary artery disease. Question why patient is not on a beta blocker. Dr. [redacted] will investigate this.

[redacted]

000010

OFFICE NOTE
PATIENT: [redacted]
DOB:
DOV: 9/30/98

HISTORY: Presents with episode of severe abdominal pain last night located mostly in her right lower quadrant. Also, moving all over her abdomen. She felt nauseous and threw up a few times. She comes to the office feeling short of breath and initially when seen was leaning forward, crying, gasping, and holding her abdomen. After talking and examination, the patient had calmed down and was smiling and laughing and walked out of the exam room without difficulty. She states she has had no fevers or chills. She continues to cough up white phlegm. She denies having chest pain or pressure. She continues to run on the treadmill with Dr. [redacted]

PHYSICAL EXAMINATION: Weight is 156 pounds. Blood pressure was 136/88. Pulse was 100. LUNGS: Clear to auscultation. CARDIAC: Regular rate and rhythm. S1, S2 without murmurs, clicks, rubs, or gallops. ABDOMEN: Soft, mild tenderness to deep palpation of the right lower quadrant. No rebound or guarding. RECTOVAGINAL: Without masses. No cervical motion tenderness. Stool guaiac negative, control positive.

EKG done STAT in the office with sinus tachycardia. No ischemia ST or T wave changes. Nonspecific high lateral T wave changes which have been seen in prior EKGs. Poor R wave progression also noted. Also seen in prior EKGs.

LABORATORY DATA: CBC with white count of 12. LFTs normal. Amylase normal. Chest x-ray clear. KUB with copious amounts of stool. Upright abdomen with several air fluid levels and gas in the small bowel.

ASSESSMENT/PLAN:

1. Abdominal pain likely secondary to constipation. Recommend prune juice which she likes. Fleet's enema. Change antibiotic to erythromycin to increase bowel motility, 500 mg p.o. q.i.d. The patient was advised if she should have persistent vomiting, unable to keep any fluids down, or worsening abdominal pain, to call physician.

[redacted] M.D.

[redacted]

PATIENT: [redacted]
DOB:
DOV: 01/19/99

HISTORY: Follow-up CABG and coronary artery disease. The patient states she is doing okay but gets chest heaviness when she exerts herself after a long day at the chocolate factory. Heaviness is located in her stomach and goes into her back. It is unlike the pain that she had with her heart attack. She also complains of constant post nasal drip and difficulties with allergies. She takes Dextral one tablet per day and this seems to help her. No headaches except occasionally. Heavy post nasal drip.

PAST MEDICAL HISTORY, SURGICAL HISTORY, SOCIAL HISTORY: No cigarettes. Works as [redacted] Factory. Notes that symptoms get a little bit worse when she is at the factory.

MEDICATIONS: Lipitor, aspirin, and Dextral.

PHYSICAL EXAMINATION: Weight is 155 pounds, blood pressure 140/90, pulse is 72 to 80. HEENT: Nares are edematous. Sinuses nontender. Oropharynx - reddened posterior hypopharynx. NECK: No adenopathy. No JVD. LUNGS: Clear to auscultation. No wheeze, rales, or rhonchus. CARDIAC: Regular rate and rhythm. S1, S2 without murmurs, clicks, rubs, or gallops. EXTREMITIES: No cyanosis, clubbing, or edema.

ASSESSMENT/PLAN:

1. Allergic rhinitis. Change to Allegra 60 mg p.o. b.i.d. and Flonase two puffs each nostril q. h.s. Recheck in one month. Check sinus x-ray to rule out sinusitis.
2. Coronary artery disease. Schedule stress echo with Dr. [redacted] and start Atenolol 25 mg p.o. q. day. Check liver and lipids on Lipitor. Follow-up in one month.

[redacted] M.D. [redacted]

OFFICE NOTE
PATIENT: [redacted]
DOB:
DOV: 01/28/99

HISTORY: Patient brought in on an emergency basis. Developed some swelling of her left lip which is not particularly itchy. She has never had anything like this before. Recently started on Bactrim DS and has been taking it faithfully. She has also been started on atenolol. The patient does not feel short of breath. However, she feels panicky that her lip is swelling.

PHYSICAL EXAMINATION: Pulse initially 100 which came down to 80 at rest. Blood pressure 138/80. Anxious. A little bit sweaty. The left lip is mildly swollen. There are no other lesions of the oropharynx. Tongue is not swollen. Hypopharynx is not edematous whatsoever nor erythematous. Cheeks are slightly flushed. NECK: Without mass. Trachea midline. No stridor. LUNGS: Clear to auscultation. No wheezes.

ASSESSMENT/PLAN:

1. Allergic reaction. Mostly like due to Bactrim DS. The patient was given Benadryl 50 mg IM and prescription for Ben[redacted]p.o. for the next every four hours. The patient is to stop Bactrim. Chart has been marked allergy. If she should develop continuous symptoms or difficulties breathing she is to go straight to the emergency room.

[redacted], M.D.

OFFICE NOTE
PATIENT: [redacted]
DOB:
DOV: 03/31/99

HISTORY: Complains of constant recurring cough. However, she has not mentioned this to the physician on prior office visits. Notes post nasal drip, dental pain, facial pain, headaches, and cough productive of phlegm and sputum. Feeling a little short of breath. Also complaining of her allergies bothering her. When seen for prior sinus infection one month ago, the patient took some of the antibiotics but developed a rash so stopped mid course. Also stopped using Flonase after several days after her nose cleared up.

MEDICATIONS: Lipitor, Allegra, atenolol, aspirin, Atrovent, and Flonase.

PHYSICAL EXAMINATION: Weight is 162 pounds, blood pressure 150/90, temperature 98.0. HEENT: Tympanic membranes are clear. Nares are edematous. Sinuses - right maxillary is tender. Oropharynx with heavy yellow discharge. NECK: No adenopathy. LUNGS: End inspiratory wheeze. No rales. Air movement is fair.

ASSESSMENT/PLAN:

1. Allergies.
2. Reactive airway disease.
3. Sinusitis. Treat with Augmentin 875 mg p.o. b.i.d. x 2 weeks. Aristocort 2 cc IM was administered to the left buttock. Start Vanceril two puffs b.i.d. with spacer device and albuterol 2 puffs q. 4 hours p.r.n. Phenergan with Codeine.

[redacted] M.D.

OFFICE NOTE
PATIENT: [redacted]
DOB:
DOV: 04/15/99

HISTORY: Recheck chest congestion. The patient is feeling much better and almost all of her symptoms are gone. She stopped taking the Augmentin because it was starting to upset her stomach about two days ago. She has been feeling fine ever since. She has scant phlegm when she coughs mostly in the morning. If she skips the Vanceril inhaler, she notes that the cough gets much worse.

PHYSICAL EXAMINATION: Weight is 162 pounds, blood pressure is 130/90. HEENT: Sinuses nontender. Oropharynx without discharge. NECK: No adenopathy. LUNGS: E to I slightly increased, otherwise completely clear.

ASSESSMENT/PLAN:

1. Allergies stable on Allegra.
2. Reactive airway disease. Continue Vanceril DS inhaler, albuterol p.r.n. for the next several months of her allergy symptoms. Note that she is on a beta blocker. However, this seems necessary for her heart disease.

[redacted] M.D.

OFFICE NOTE
PATIENT: [redacted]
DOB:
DOV: 05/03/99

HISTORY: Dysuria, urgency, frequency. Slight back pain. No fevers or chills.

PHYSICAL EXAMINATION: Weight is 163 pounds. BACK: No CVA tenderness. Lab: urinalysis with 2+ leukocyte esterase and positive nitrates.

ASSESSMENT/PLAN:

1. UTI. Cipro 500 mg p.o. b.i.d. x 3 days.

[redacted] M.D.

000016

[redacted]

November 30, 1998

[redacted]

RE: [redacted]

Dear [redacted]

The above-captioned patient has finished her treatment at our center. The patient was exercised using bicycle ergometers and treadmill modalities. She was well motivated and attended the sessions regularly. She, in addition, watched numerous films on risk factor modification and seemed to be oriented towards a healthy lifestyle.

Because of less than ideal lipids in the past, she has been started on Lipitor 20 mg daily. On that regimen, her recent cholesterol shows an improvement from a total cholesterol of 223, down to a total of 157. Triglycerides have dropped from 245 to 173. HDL has risen from 21 to 40. LDL has dropped from 153 to 82. These are optimal numbers and the patient should continue on Lipitor 20 mg daily in addition to her aspirin one daily. Repeat lipid panel would be useful in about three months to assure both the patient's compliance and effect.

The patient had a post discharge treadmill which showed that her percent MHR achieved went from 88% to 96%. Metabolic units achieved went from 7 to 10.1. Exercise time on the Bruce protocol increased from 4 minutes and 20 seconds to 7 minutes and 5 seconds. There was no evidence of myocardial ischemia. Good exercise tolerance and normal blood pressure response to exercise. No ectopy or chest pain.

In short, I feel the patient has benefitted significantly from her treatment and I wish to thank you very much for the referral.

Sincerely,

[redacted]

[redacted] M.D.

[redacted]

000017

[redacted] FINAL REPORT

Patient: [redacted] Physician: [redacted] Date: 7/24/98

Address: Phone:

Patient ID: Height: Weight: Age: 41 Sex: M (F)

Brief History: ASHD s/p CABG

Medications: Target HR: 90%=151

Protocol: BRUCE V5 ST Level at J + 60ms V5 ST Slope from J + 0ms to J + 60ms

Event	Speed (MPH)	Grade (%)	HR (BPM)	ST Level (mm)	ST Slope (mm/sec)	Comments
rest	1		125	+0.0	+3	172/70
stage 1	1.7	10.0	145	-0.3	+3	125/70 125/70 145/70
stop exercise @ 4:20			148	-0.5	+3	145/70
recovery @ 2:00			122	-0.1	+3	135/[redacted]
recovery @ 4:00			118	+0.0	+1	135/[redacted]

Interpretation: METS achieved: 7.0

88% MHR : 7.5 METS
TEST TERMINATED BECAUSE OF FATIGUE.
NO CHEST PAIN
NORMAL BP RESPONSE TO EXERCISE
NO ECTOPY
DECREASED EXERCISE TOLERANCE.
NO EVIDENCE OF MYOCARDIAL ISCHEMIA.

[redacted]

[redacted]

[redacted] FINAL REPO[redacted]

Patient: [redacted] Physician: [redacted] Date: 11/24/98

Address: [redacted] Phone:

Patient ID: Height: Weight: Age: 61 Sex: M (F)

Brief History:
AFIB s/p CARDIAC REHAB

Medications: Target HR: 90% = 151

Protocol: BRUCE V5 ST Level at J + 60ms V5 ST Slope from J + 0ms to J + 60ms

Event	Speed (MPH)	Grade (%)	HR (BPM)	ST Level (mm)	ST Slope (mm/sec)	Comments
rest	1		101	+0.1	+0	140/88
stage 1	1.7	10.0	142	+0.1	+5	140/85 155/85 155/80
stage 2	2.5	12.0	153	+0.0	+3	160/80 160/80 162/80
stop exercise @	7:05		163	-0.2	+3	145/[redacted]
recovery @	2:00		125	+0.0	+5	160/80
recovery @	4:00		114	-0.1	+3	140/80

Interpretation: METS achieved: 10.1

96% MHR ; 10.1 METS
NO CHEST PAIN.
NO ECTOPY.
NORMAL BP RESPONSE TO EXERCISE.
GOOD EXERCISE TOLERANCE.
NO EVIDENCE OF MYOCARDIAL ISCHEMIA.

	% MHR	METS	EXERCISE TIME
PRE-REHAB	88%	7.0	4:20
POST-REHAB	96%	10.1	7:05

000019

[redacted]

[redacted]

12979

[redacted]

[redacted]

[redacted]

February 16, 1999

'99 JUL 14 P3:09

CLINICAL REVIEW

[redacted]

RE: [redacted]

Dear Doctor [redacted]

Thank you once again for allowing me to reevaluated [redacted]

DIAGNOSIS:

1. Arteriosclerotic heart disease:

   a. Previously demonstrated ostial left main trunk stenosis.

   b. Status post CABG, performed 6-98, with LIMA to LAD (occluded), patent SVG to first diagonal branch, with perfusion of the entire left coronary artery system and no significant narrowing of the nonbypassed RCA.

   c. Atypical chest pain determined not to be ischemic in origin.

2. History of hyperlipidemia.

3. History of hypertension.

[redacted]

CURRENT MEDICATIONS:

1. Lipitor, 20mg. qd.
2. ASA, 325mg. qd.
3. Atenolol, 25mg. qd.

PERTINENT HISTORY: The patient is a 61 year old widowed white female packager in a chocolate factory who, as you know, presented 6-98 with unstable angina and was found to have ostial stenosis of the left main trunk with minimal narrowing of the LAD.

[redacted]

She subsequently underwent implacement of a LIMA graft to the LAD and a saphenous vein graft to the large diagonal branch. The RCA at that time was essentially normal with a minor luminal narrowing of no greater than 20%, and left ventricular function was normal.

I gather that for a period of time she was asymptomatic, participated in Doctor [redacted] cardiac rehabilitation program, and was doing reasonably well.

However, over the past few months she has experienced an atypical sedentary form of chest pain which is felt as a heavy anterior chest discomfort, almost always occurring when she is at work with her arms extended packaging and wrapping chocolates.

She did undergo a treadmill exercise test on 1-16-99 in which she could only exercise to the third minute of Stage II of the Bruce Protocol achieving only 75% of her predicted maximum heart rate, which is below the limits of diagnostic ability. Therefore, because of her continuing chest discomfort, it was felt that coronary angiography was indicated.

On 2-11-99 the patient underwent cardiac catheterization. This study demonstrated that the LIMA graft did not perfuse the LAD and was essentially totally occluded in its mid third segment.

However, the large vein graft to the diagonal is widely patent and in the absence of any significant disease within the LAD or diagonal branches allows complete perfusion of the entire anterolateral wall including the circumflex coronary artery.

As you will note from the enclosed pictures, there is a large lateral thoracic branch which was not ligated at the time of surgery. This is a somewhat controversial area in cardiology as coronary Doppler flow wire testing has previously indicated that since most of the flow in a coronary artery occurs during diastole a "steal" type situation should not develop with a lateral thoracic branch.

I have enclosed for your review a recent discussion on that subject by Doctor [redacted] His basic position is that "preferential" blood flow to the chest wall has rarely been measured and that systemic arterial flow is predominantly systolic and out of phase with the diastolic flow that occurs in a coronary artery.

In any case, the bottom line with Mrs. [redacted] is that I was not able to demonstrate ischemia and it is my opinion that her chest discomfort at this time is probably related to chest wall pain aggravated by her form of work, with adhesions developing between the sternum and the pericardial lining.

As I have previously indicated, Mrs. [redacted] apparently has not been very active since her cardiac rehabilitation program and very much needs to start a full out regular exercise program.

She remains on aspirin and beta blockers which I believe are appropriate given the extent of her coronary disease.

Once again, I appreciate the opportunity to be involved in her care.

Best regards,

[redacted]

Enc.

[redacted]

[redacted]

[redacted]

TREADMILL EXERCISE TEST

PATIENT: [redacted]

DATE: 1-26-99

REFERRING DOCTOR: Dr. [redacted]

RESTING EKG: Normal sinus rhythm; T inversion in AVL; Otherwise within normal limits.

CONCLUSION: Limited exercise tolerance test with maximum heart rate reduced by beta blockade and leg fatigue; Negative for ST-T changes of ischemia; Negative for arrhythmias.

[redacted]

[redacted]

000023

[redacted]

GRADED EXERCISE SUMMARY

[redacted]
ID:

61yrs
26-JAN-1999 67in 156lbs
11:09:47 Meds.: SEE CHART

Female

Ref. By: [redacted]
Test Ind.: STRESS ECHO
Technician:
:
:

BRUCE Total Exercise Time: 6:56
Max HR: 120bpm 75% of Max Predicted 159bpm
Max BP: 142/76 Maximum Workload: 8.2METS
Edit Comments:

25mm/s
10mm/mV
100hz

000024

Phase Name	Stage Name	Time in Stage	Speed (mph)	Grade (%)	WorkLoad (METS)	HR (bpm)	BP (mmHg)	RPP (x100)
PRE-TEST	SUPINE	0:00	0.0	9.1	1.0	83		
	STANDING	0:00	0.0	9.1	1.0	84	120/80	101
EXERCISE	STAGE 1	3:00	1.7	10.0	4.6	102	138/70	141
	STAGE 2	3:00	2.5	12.0	7.0	117	142/76	166
	STAGE 3	0:56	0.0	13.2	4.2	***		

[redacted] M.D.

Confirmed By: Date:

Version 001F

[redacted]

GRADED EXERCISE SUMMARY

[redacted]

ID: [redacted]

61yrs Female

26-JAN-1999 67in 156lbs

11:09:23 Meds.: SEE CHART

Ref. By: [redacted]

Test Ind.: STRESS ECHO

Technician:

:

:

BRUCE Total Exercise Time: 6:56

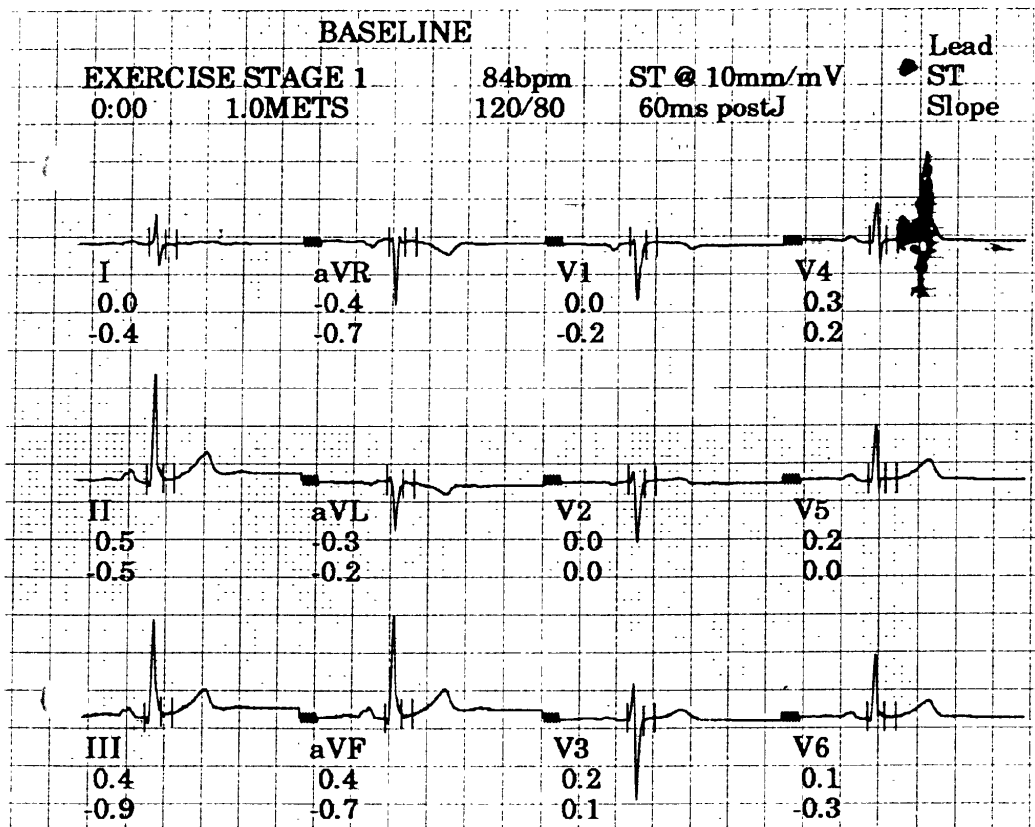
Max HR: 120bpm 75% of Max Predicted 159bpm

Max BP: 142/76 Maximum Workload: 8.2METS

Edit Comments:

25mm/s
10mm/mV
100hz

000025



[redacted]

Version 001F

Confirmed By: Date:

[redacted]

[redacted] ID: 26-JAN-1999 10:33:23

25mm/s Meds.: SEE CHART
10mm/mV 61yrs 67in 156lbs NORMAL SINUS RHYTHM
20hz Female NORMAL ECG

12SL v78

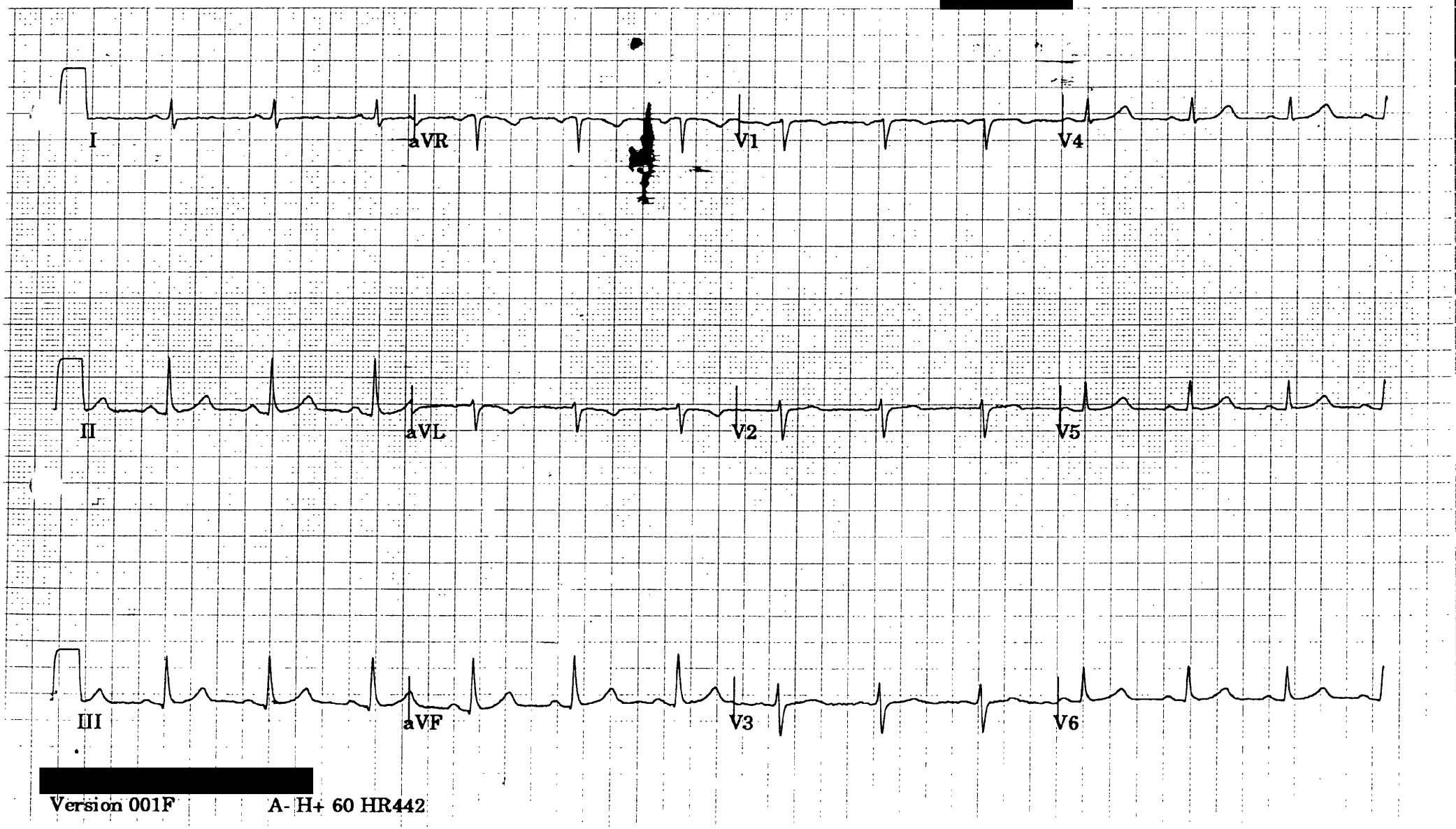
Vent. rate 76 bpm
PR interval 160 ms
QRS duration 72 ms
QT/QTc 400/450 ms
P-R-T axes 61 83 61

[redacted]

Ref. By: DR. [redacted]

[redacted]

000026



[redacted]

Version 001F A- H+ 60 HR442

[redacted]

LINKED MEDIANS REPORT

[redacted]
ID:

26-JAN-1999
11:06:44

119bpm

EXERCISE
STAGE 3
6:49

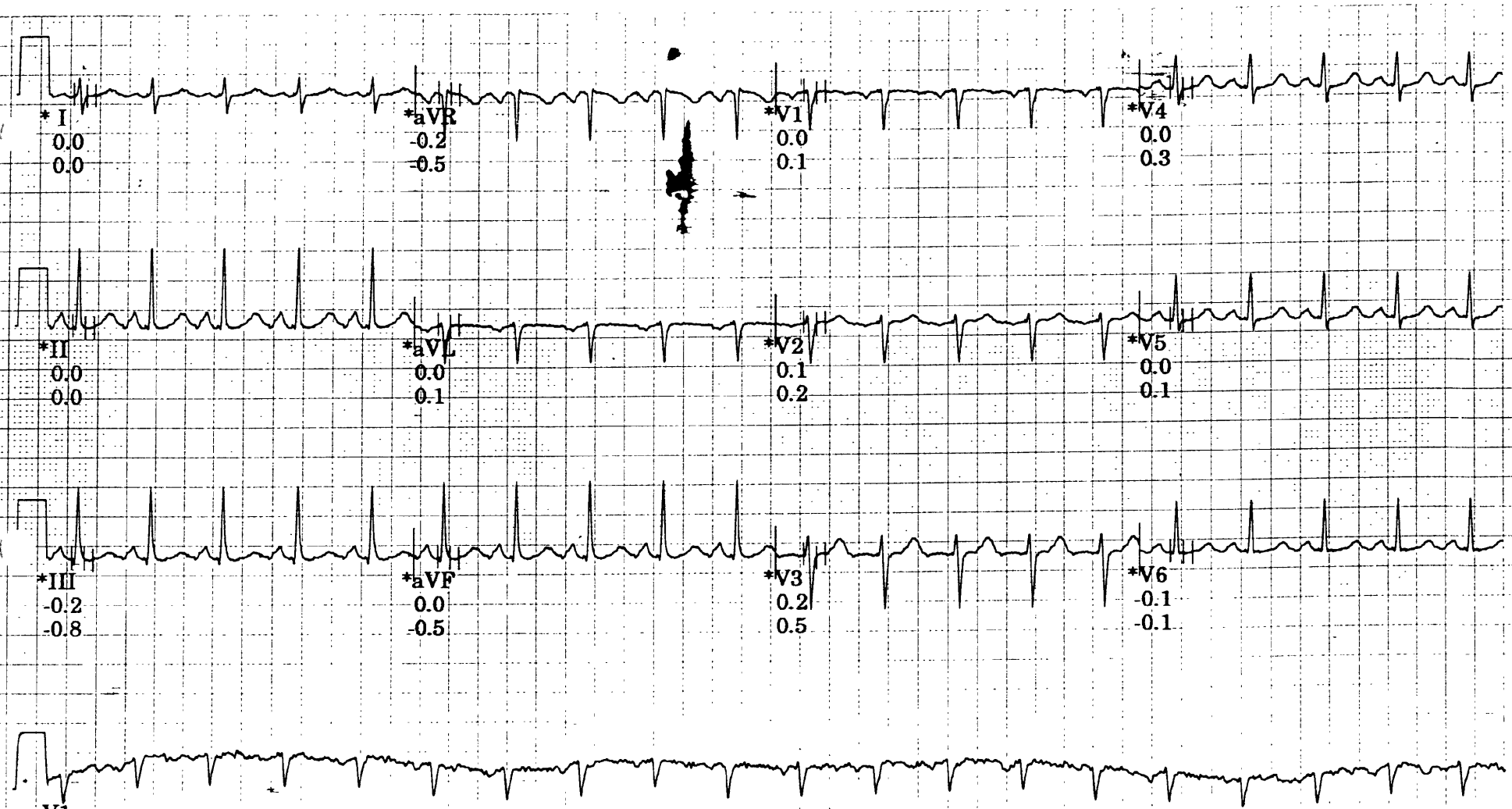
BRUCE
3.4 mph
14.0 %

25mm/s
10mm/mV
20hz

000027

Lead
ST
Slope

ST @ 10mm/mV
60ms postJ



Raw Rhythm

[redacted]

* Computer Synthesized Rhythm

[redacted]

[redacted]

[redacted]

NAME: [redacted]

REFERRING PHYSICIAN: [redacted]

[redacted]

TAPE: [redacted]

DATE: 1-26-99

CLINICAL INFORMATION:

Coronary artery disease

Hypertension

MEASUREMENTS:		**LEFT VENTRICLE:**	
Aortic Root:		ID Diastole (38-57)	46mm
Diameter (<37)	28mm	ID Systole (22-40)	30mm
Leaflet Separation		Septal Thickness	14mm
Left Atrium	37mm	Posterior Wall	13mm
Mitral Valve:		Septal Motion	
Right Ventricle (7-25)	17mm	Doppler with Color Flow	X

LEFT VENTRICLE: Left ventricular hypertrophy without cavitary dilitation. Normal left ventricular systolic function with ejection fraction of 65%. Reversed E-A doppler wave form suggests abnormal relaxation phase.

VALVES: Normal aortic, mitral, tricuspid and pulmonic valves in appearance and function without evidence of ıosis or insufficiency. No leaflet deformity on 2-D echocardiogram study.

RIGHT HEART: No evidence of pulmonary hypertension.

OTHER: No clots, filling defects, effusion or arrhythmias. Oxygen saturation rate of 98% at heart rate of 78 BPM at rest.

POST STRESS ECHOCARDIOGRAM: NEGATIVE FOR INDUCTION OF REGIONAL WALL MOTION CHANGES AFTER EXERCISE. OXYGEN SATURATION RATE OF 98% AT HEART RATE OF 92 BPM TAKEN WITHIN 1 MINUTE POST EXERCISE.

[redacted] M.D.

000028

[redacted]